

FAMILY PRESENCE DURING CARDIOPULMONARY RESUSCITATION

A RESEARCH PAPER

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RESEARCH PAPER: Nurses beliefs' about family presence during resuscitation
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The concept of family presence (FP) during cardiopulmonary resuscitation (CPR) has been studied and debated as far back as 1987. This concept continues to be debated among nurses. Literature suggests that the previously surveyed sample of nurses, which focused on acute care nurses, should be expanded to include nurses caring for patients in all hospital care areas including general medicine, pediatrics, and cardiac outpatient rehabilitation. The purpose of this study is to explore current nurses' beliefs and experiences about FP during CPR. This study is a replication and expansion of Knott and Kee's (2005) study. The study will be conducted at a basic level of specific qualitative descriptive methodological design which allows for selection of a broad area of inquiry while maintaining a limited sample size. The target population will be nurses from a variety of hospital care settings. Inclusion criteria will be that nurses must have at least four years of clinical experience and are likely to be either witnesses to or participants in CPR procedures where families were on-site. Furthermore, nurses in the sample will represent multiple types of work responsibilities and locales including staff nurses, charge nurses and managers. Semi-structured interviews using open-ended questions, will be conducted and focus on the nurses' current beliefs and experiences regarding FPDR. Data will be analyzed using the constant comparative method and will look for

themes. Findings from this study will contribute to the design of interventions for nurses to actively participate in the implementation of a hospital FPDR program.

Chapter I

Introduction

After decades of debate, healthcare providers continue to struggle with having family members at the bedside during cardiopulmonary resuscitation in the hospital setting. During the 1950s over 50% of deaths occurred in the home, frequently with the family members at the bedside during the death of their loved one (Meyers, 1998). Since the 1970s, this practice has gradually changed due to advances in medicine and the introduction of both cardiopulmonary resuscitation and electronic communication between emergency department and rescue emergency medical technicians (EMTs). More non-hospice deaths now occur in the hospital. Family members are often viewed as visitors and, in many cases, must adhere to visitation policies. Despite marked cultural changes since the advent of cable/satellite television and internet streaming video, where surgeries and trauma units can be viewed in high definition color in real time, family members are still urgently escorted out of the patient's room and are routinely prohibited from being with their loved one during resuscitative efforts. Given the current day shift to private patient room, relationship based care, family centered care, and patient centered care, it is time for family presence to be re-addressed and hospital programs established regarding families being given the option to be at the bedside during resuscitative efforts of a loved one. At present, the American Association of Critical-Care Nurses (AACN), the American Heart Association (AHA), the American Academy

of Pediatrics (AAP), the Ambulatory Pediatric Association (APA), and the Emergency Nurses Association (ENA) all recommend the option of family presence during resuscitation, (American Association of Critical-Care Nurses [AACN], 2004; American Heart Association [AHA], 2005; Emergency Nurses Association [ENA], 2001; (Henderson & Knapp, 2005).

Literature has documentation of family members requesting to be at the bedside of their loved ones during resuscitation for the past several decades. The literature search revealed that in 1982 on two separate occasions at Foote Hospital in Jackson, Michigan, family requested to be with their loved ones during resuscitation (Hanson & Strawser, 1992). Nurses continue to struggle with the request from family members more than 25 years later. There are mixed beliefs regarding the concept and for the most part, nurses are without institutional guidelines on family presence during resuscitation (FPDR).

Problem

Updated and additional information is needed regarding nurses' beliefs and feelings about family presence during resuscitation. Minimal research has focused on nurses' opinions in non-emergency areas of care nor has research included general pediatric nurses' beliefs (Knott & Kee, 2005). According to the available literature, there exists a broad spectrum of practice on FPDR. Many organizations do not address the practice and few healthcare institutions have policies or programs supporting FPDR. The lack of policy or program leaves nurses unprepared to address the request when made by family members. All hospital staff nurses deserve to be prepared to therapeutically

address the requests for family members to be at the bedside of their loved one during resuscitation.

Purpose of the study

The purpose of this qualitative study is to explore current (2010-2011) family presence during resuscitation beliefs and attitudes of registered nurses who provide care to all ages of patients in a variety of hospital care settings. The goal of this study is to provide valid and informative data for global discussion and specific institutional program guidance relating to FPDR.

Research Question

The primary research question for this study is: Do commonalities exist among emergency, acute care, non-acute care and managerial nurses regarding their current beliefs and attitudes for FPDR.

Theoretical Framework

The theoretical framework for this study will be Lewin's (1951) Change Theory. Lewin's theory viewed behavior as a dynamic balance of forces working in opposite directions. Through his studies he recognized that driving forces facilitate change because they push groups in the desired direction. Restraining forces hinder change because they push groups in the opposite directions. The opposing forces must be analyzed and Lewin's three-step model can help shift the balance between the groups in the direction of the planned change.

Definition of Terms

Family presence during resuscitation (FPDR).

Conceptual Definition: Family will be present during the resuscitation of a family member.

Operational Definition: The actual location of family members during a family member's resuscitation

Nurse beliefs and attitudes about FPDR.

Conceptual Definition: Nurses beliefs and their attitudes about family members being present during the resuscitation of a loved one.

Operational Definition: FPDR beliefs and attitudes will be recorded from answers to questions in nurse interviews and then categorized into themes.

Limitations

Only nurses will be interviewed about their FPDR beliefs and attitudes. Other stake-holders in family presence during resuscitation are not included as study participants such as physicians, respiratory therapists, patients, and family members. The sample size is also limited for generalizability of study findings to the overall population of nurses.

Assumptions

The following assumptions underlie this study:

1. Nurses have beliefs and attitudes about FPDR.
2. Nurses will answer questions about their FPDR beliefs and attitudes.

Summary

The clinical practice of excluding adult family members from the bedside during resuscitation needs to be re-addressed for today's society. The ENA developed a program guide establishing a process for initiating a program of family presence during invasive procedures and resuscitation. One step in the process of developing a family presence program is to assess the institution and its departments for staff nurse beliefs and attitudes on this topic. Conducting a survey of nurses allows for identification of attitudes, concerns and beliefs as well as current practices of individuals. This information provides fundamental data to guide discussions and serves as a basis for developing strategies for acceptance of FPDR. Overall, the assessment helps to identify potential road blocks, resistance and support for a family presence program (ENA, 2005). Equipped with this information, a change theory may be applied to the problem to facilitate a paradigm shift. Healthcare facilities can shift from a culture that did not support FPDR to a culture that supports the option for family members to be at the bedside with a loved one during resuscitation.

Chapter II

Review of Literature

Introduction

Chapter 2 presents a review of literature on FPDR and invasive procedures. There have been numerous studies conducted over the past 25 years covering the subject of family presence (FP) during resuscitation. Data is available on staff attitudes, family attitudes and patient attitudes. Information on nurses' perceptions of their self-confidence and the benefits and risks of FP are documented. The frequency and magnitude of obstacles and supportive behaviors for FP are revealed in multiple studies. Available research also focuses on staff attitudes from abroad as well as nurses in the United States. The available research also includes family members and patient's perspectives on FP with adult patients' as well as the pediatric patient population. The majority of the research focuses on nurses in emergency departments and critical care areas, yet minimal research has been done to explore the beliefs and attitudes of nurses' providing care to all ages in a variety of care settings. The following review of literature will support the need for additional research of licensed nurses who work in a wide range of care settings.

Theoretical Framework

The theoretical framework for this study will be Lewin's (1951) Change Theory. Lewin's theory viewed behavior as a dynamic balance of forces working in opposite

directions. Through his studies he recognized that driving forces facilitate change because they push groups in the desired direction. Restraining forces hinder change because they push groups in the opposite directions. The opposing forces must be analyzed and Lewin's three-step model can help shift the balance between the groups in the direction of the planned change.

The three phases of Lewin's theory are:

1. Unfreezing – The change agent must first experience dissatisfaction with the current situation such that the status quo is unacceptable and the need for change is recognized.
2. Change or transition – Strategies and alternatives for change are clearly identified and driving forces must outweigh restraining forces to set change in motion.
3. Refreezing – The change agent must provide support to the staff so that managing a crisis situation is not uncommon for critical care and emergency nurses; this is something they are faced with on a day to day basis. These nurses must be prepared to handle the patient situation as well as the family dynamics. Increasingly, more patients' families are remaining at the bedside adaptation to the new change is accepted and integrated into the organization (Lewin, 1951).

Practices of Critical Care and Emergency Nurses

During cardiopulmonary resuscitation (CPR) and invasive procedures, but the practice continues to be controversial. A study was performed by MacLean, Guzzetta,

White, Fontaine & Eichorn (2003) to evaluate the practices of critical care and emergency nurses during CPR and invasive procedures.

MacLean et al. (2003) mailed a survey to a random sampling of 1500 nurses from critical care areas who were members of the American Association of Critical-Care Nurses (AACN). The survey was also mailed to a random sampling of 1500 emergency department nurses who were members of the Emergency Nurses Association (ENA). All 3000 nurses surveyed were registered nurses. The study was approved by the institutional review board at one of the investigators hospital, the AACN and the ENA.

A 30-item survey was developed by the research team. The tool included 20 questions regarding demographic characteristics of respondents; 9 questions about respondents' practices, preferences, and hospital policies relating to family presence during cardiopulmonary resuscitation; and one question giving respondents' the opportunity to share any comments about their personal or professional experiences with family presence. MacLean et al. (2003) also included definitions of family presence that was developed specifically for the study. Included in the packet was a cover letter that detailed the aim of the study, a request to return the survey once completed, and a guarantee of anonymity.

Content validity of the tool was established by a national panel of experts consisting of 3 critical care nurses, 3 emergency nurses, and 1 physician. This panel rated the relevance and clarity of the instrument. All seven experts rated 100% of the content as relevant in measuring the nurses' practices with family presence. MacLean et al.

(2003) did not delete any of the questions; they did, however, revise 7 items based on the feedback they received from the expert panel.

Findings in that study revealed that of the RNs responding 5% worked in areas with written policy and 45% and 51%, respectively, worked in areas that practiced FPDR without written policy. Written policy for CPR was preferred by 37% of RNs and 35% for invasive procedures; whereas, unwritten policies were preferred by 36% for CPR and 44% for invasive procedures. MacLean et al. (2003) discovered about one fourth of the nurses reported that family presence was prohibited for CPR and invasive procedures even though their respective areas had no written policy prohibiting this practice.

MacLean et al. (2003) concluded that several important implications were found for practice as well as research: with the request from so many families' critical care and emergency nurses need to make a position statement on where they stand. Research is also needed to explore the implications of so many RNs practicing this concept without written policy. There is also a need to explore the difference between the number of RNs not taking family to the bedside (40%) and the number of families requesting to be at the bedside.

Nurses Beliefs about Family Presence Resuscitation

Even though family presence during resuscitation (FPDR) has been practiced for several decades, it continues to be a topic of debate. There are several perceived negative aspects of FPDR including: increased stress for staff, long-lasting adverse emotional effects of stress for a family and increased possibility of litigation, especially in those cases with adverse outcomes. Studies conducted in recent years have shown FPDR can

have a positive impact on both family and staff regardless of patient outcome. The majority of this research was collected from staff and families involved in emergency department resuscitations with adult patients. To enrich the body of research, Knott and Kee (2005) conducted a study exploring the beliefs and experiences of FP from nurses working in a variety of acute care settings.

The sample consisted of interviewing a variation of 10 RNs employed in different acute care settings with different work responsibilities that had at least four years of clinical experience. Knott and Kee (2005) believed this sampling process would obtain maximum variation in perspectives on the FPDR phenomenon. No additional criteria were required and all participants were professional acquaintances of the author who informed them of the study and invited them to participate.

The study is at a basic level of qualitative descriptive methodological design. Knott and Kee (2005) conducted semi-structured interviews consisting of open ended questions adapted from the Parkland Health and Hospital System (1997). The interview questions focused on the nurses' beliefs and experiences about (FP) during CPR. Demographic and background information on age, sex, nursing education and clinical experiences were gathered, categorized and summarized. The authors analyzed the responses to the interview questions utilizing the constant comparative method of data analysis.

Knott and Kee (2005) identified four themes that emerged from the data analysis. The first theme that emerged was that there are situations when FP may or may not be a viable option. The second theme identified was the use of FP to force family decision

making. A feeling of “being watched” was the third theme revealed and lastly, the impact of FP on family was a potential fourth or emerging theme from the data.

Knot and Kee (2005) concluded that the nurse participants believed that some families benefit from FPDR whereas others do not and individualized care is central to success with FPDR.

Emergency Nurses’ Current Practices and Understanding of FPDR

The Emergency Department is the most common area in the hospital for a cardiac arrest to occur. When death occurs, it is most frequently as a result of an unforeseen or unanticipated event that has a profound acute effect on any family. The presence of family members in the resuscitation area is a controversial issue and not universally accepted among the health care profession. Madden and Condon (2007) conducted a study to examine the current practices and understanding of nurses and doctors in Emergency Departments on the process of family presence.

The population for their study consisted of a convenience sample of 100 emergency nurses at Cork University Hospital with at least 6 months emergency nursing experience in a large level 1 trauma center. All nurses were involved in working in the resuscitation room and dealing with resuscitation efforts. Madden and Condon (2007) obtained ethical approval through the Clinical Research Ethics Committee of the Cork Teaching Hospital (Cork, Ireland) which is comparable to an IRB in the United States. They also received written consent from the Director of Nursing, Clinical Nurse Manager and Senior Consultant of the Emergency Department.

A survey questionnaire consisting of 15 closed-ended questions was utilized for the study. Madden and Condon (2007) had four objectives in mind. The first consisted of demographic information including age of participant, sex, nursing qualification. The second was to determine nurses' level of knowledge on current policies regarding FPDR. Objective number three was to determine the preferences and practices of emergency nurses on FPDR and finally the fourth objective was to identify road blocks and facilitators permitting family presence during FPDR.

Of the 100 questionnaires distributed, a total of 90 were returned completed, representing a favorable response rate of 90%. Females made up 83.3% of the respondents in the 30 to 40 year age group working as staff nurses. Madden and Condon (2007) noted that the respondents reported having a high level of nursing qualifications.

The results of the study revealed that 65% of the nurses answered correctly that no formal policy existed in the emergency department on FPDR during CPR. This revealed that one third did not know if such a policy existed or not. Results also illustrated that 74% of emergency nurses would prefer a written policy allowing families the option of FPDR during CPR. Madden and Condon (2007) pointed out that surprisingly almost two thirds of the nurses took families to the bedside during CPR and 20% of the respondents prefer not to have a written policy. The most significant barrier to FPDR was the conflicts occurring within the emergency team. 58% of the nurses believed a significant barrier to FPDR was conflict with the medical staff. The most significant facilitator identified to FPDR was a greater understanding by the healthcare

professionals on family witnessed resuscitation (FWR) to patients and families and the necessity for educational development.

Madden and Condon (2007) concluded that their study heightened the awareness and knowledge of emergency department nurses on FPDR. It displayed a need for research, education and policy development in the clinical setting.

Frequency and magnitude of obstacles and supportive behaviors

Death is an expected outcome of life and more patients die in emergency departments than any other department in health care facilities. In 2002, an estimated 272,000 patients either died in emergency departments across America or were pronounced dead on arrival at emergency departments (Beckstrand, Smith, Heaston & Bond (2008). The nurses working in emergency departments are expected to know best what is needed to care for patients and their families to improve end-of-life (EOL) care. The goal of Beckstrand et al. (2008) was to gain knowledge from emergency care nurses to increase and facilitate conversations surrounding perceived obstacles and supportive behaviors that focus on EOL care.

After obtaining institutional review board approval a random sample of 700 emergency care nurses was obtained from the national Emergency Nurses Association (ENA). ENA membership totaled 28,724 as of December 2005, so the 700 member sample represented a 2.4% of total membership. This sample size was seen as appropriate as it exceeded 2% of the total ENA membership. Beckstrand et al. (2008) considered nurses eligible if they had worked in an emergency department at some time, lived in the United States, could read English, and had taken care of at least one patient at

the EOL in an emergency setting. Consent to participate was assumed upon return of a completed survey.

The instrument utilized was adapted from a 28 listed obstacle questionnaire used in an early study of emergency department nurses perceptions of EOL care. Beckstrand et al. (2008) eliminated three items from the survey which received the lowest mean scores based on the results an earlier study. The deleted items were: (a) the nurse knowing about the patient's prognosis before the family is told; (b) continuing to provide advanced treatments to dying patients because of financial benefit to the organization; and (c) physicians who are overly optimistic. A similar process was used to eliminate two supportive behaviors that received the lowest mean score. Those items were: (a) physicians who put hope in real tangible terms by saying to the family that, for example, 1 out of 100 patients with this condition recover; and (b) having unlicensed personnel available to care for the patient. The authors also received feedback from participants in the original study to consider three new supportive behaviors. The new supportive behavioral items added to the questionnaire were: (a) an emergency department designed to provide adequate privacy for a dying patient; (b) nurses receive additional education on caring for the patient and family during EOL situations; and (c) allowing the nurses the opportunity to participate in a debriefing session after a traumatic death.

A total of 384 questionnaires were returned from the 700 potential respondents. 112 of the 384 questionnaires were eliminated from the study sample either due to the questionnaire not being deliverable or the recipient was ineligible. The main reason for ineligibility was that respondents were not currently working in an emergency

department. After three mailings, the final number of responses was 272 which equaled a response rate of 46.3%.

Demographic information displayed 84.6% of respondents were female with a mean age of 47.3. The mean years as a registered nurse was 20.1 and mean years in the ED were 14.5. Level of educational displayed that 64.4% of the nurses responding held a bachelors degree or higher and 59.2% were board certified emergency nurses (Beckstrand et al., 2008).

The findings revealed the three highest supportive behaviors were; (1) allowing family members adequate time to spend alone with their loved one after the person had died; (2) having good communication between the doctors and nurses that are caring for the dying patient; and (3) providing a peaceful, dignified bedside environment for the family after once the patient has died. Beckstrand et al. (2008) revealed the three lowest scoring supportive behaviors as: (a) the chance to participate in a professional debriefing session after a traumatic death; (b) having a discussion with the patient about his/her feelings about dying; and (c) having appropriate time to prepare the family for the expected death of a loved one. The obstacle that received the largest magnitude score was the emergency nurse having work loads too high to allow appropriate time to care for dying patients and their families. The ENA supports this work load sentiment and has found the issue of staffing and productivity in emergency rooms to be an issue of importance, as supported by their position statement that was developed as early as 1987 and revised as recently as 2003. Evidence supports the statement as it shows staffing ratio influence patient outcomes-both quantitatively and qualitatively.

The authors concluded that the results of their study would hopefully open up discussions regarding EOL care in emergency departments. Beckstrand et al. (2008) evaluated the highest scoring obstacles to determine improvements that may be implemented to decrease barriers in providing EOL care to dying patients. Initial implications might be decreasing work load of emergency nurses providing direct patient care. Lower scoring supportive behaviors should be examined to lead nurses as they provide EOL care. Increasing the frequency of education on EOL care would be an answer to reverse the low supportive score. The study supports further research being needed to look at ways to decrease obstacles with the highest magnitude and increase the high magnitude supportive behaviors to provide a higher level of EOL care in emergency departments.

Nurses' perceptions of their self-confidence and benefits and risks of FPDR

Family presence during resuscitation (FPDR) continues to be a topic of debate around the world. Research suggests there is a difference of opinion amongst healthcare professionals with physicians, particularly residents and interns, not being in favor of this practice. The majority of the research to date has been conducted with emergency department nurses and some critical care nurses. Healthcare professionals report 3 primary reasons for their reluctance to invite patients' families to be present: the unpleasantness of what families will see, fear that the resuscitation team will not function well with patients' families in the room, and anxiety that family members will become disruptive (Twibell et al., 2008). The objectives of this 2008 study involved testing 2 instruments to measure nurses' perceptions of FPDR, evaluate demographic indicators

and the perceptions of nurses' self confidence and the risks and benefits related to such FPDR in a broad sample of nurses from multiple hospital units, and to examine the differences in perceptions of nurses who have and who have not invited family to the bedside during resuscitation.

Participants for that study consisted of registered nurses (RNs) and licensed practical nurses (LPNs) that were employed by Ball Memorial Hospital, a regional medical center associated with Ball State University in Muncie, Indiana. Ball Memorial did not have a policy on FPDR and nurses on some units of the hospital routinely used FPDR and others did not. To be included in the study participants had to be 18 years or older, able to read English, and hold a current Indiana state nursing license. Twibell et al. (2008) had the study approved by the appropriate IRB. The nurses participating in the study completed 2 instruments and returned them via mail. Data were held confidential and participation was voluntary.

Perceptual variables in the study were perceived risks, perceived benefits, and self-confidence related to FPDR (Twibell et al., 2008). The authors developed 2 instruments to measure perceptual variables based on Rogers and Bandura, qualitative data from content experts, and from the results of previous research. The Family Presence Risk-Benefit Scale (FPR-BS) measured the nurses' perceptions of the risks and benefits of FP to the family, patient and resuscitation team. The Family Presence Self-Confidence Scale (FPS-CR) measured the nurses' level of self confidence in managing FP with patients' families present. Items on both scales used a 5-point Likert response, from strongly disagree = 1 to strongly agree = 5. Demographic variables included age,

sex, ethnicity, educational level, nursing role, RN or LPN, professional certification and years of experience as a nurse. The research group also included a single item that asked, “How many times have you invited a family member to be present during a resuscitation attempt at this hospital?” Participant’s response options were never, fewer than 5 times, and 5 times or more.

A total of 375 nurses participated in the study for a response rate of 64%. The findings from this study revealed a wide range of responses from participants, from strongly agree to strongly disagree reflecting the continuing controversial nature of FPDR. The results also revealed emergency departments RNs that were certified and belonged to a professional organization were most likely to invite family to the bedside during resuscitation. Twibell et al. (2008) shared additional findings that suggested once nurses participated in family presence, they perceived more benefits than risks in the practice and had a higher level of self confidence.

The authors concluded that nurses continue to have a wide variety of perceptions of the risks, benefits, and their own level self-confidence in regard to FP. Increased participation in professional nursing organizations may provide greater exposure to current research and evidence-based practices related to family presence (Twibell et al. 2008). Initial testing of the FPR-BS and FPS-CS indicate that the scales do provide reliable and valid measures; however, further testing of both scales is needed, with the goal of developing highly reliable and valid instruments to measure nurses’ perceptions of FP and their level of self confidence.

Attitudes toward and beliefs about family presence

Family centered-care is an approach of caring for the patient as well as the family or significant others. With this approach the health care providers take into account what might benefit each individual family situation. In a study conducted by Duran, Oman, Abel, Koziel & Szymanski (2007) the purpose was to describe and compare the beliefs and attitudes toward FPDR of healthcare providers, patients' family members and patients regardless of previous experience with FPDR.

A descriptive survey design was utilized to collect quantitative data and qualitative comments utilizing open-ended questions. Data was collected from healthcare providers in the emergency department, neonatal intensive care unit, medical, surgical, neurosurgical and burn/trauma intensive care units at the University of Colorado Hospital, a 300-bed academic hospital in Denver, CO (Duran et al., 2007). The research team collected data from September 1, 2003 through November 30, 2003.

With permission, Duran et al. (2007) adapted surveys that were used from the family presence study completed at Parkland Health and Hospital System, Dallas, TX. The survey given to the healthcare providers consisted of 47 items, the family survey also had 47 items, and the patient survey had 42 items. The surveys were written in interview format with the items being scored on a 4 point Likert scale. Possible responses were strongly disagree (1), disagree (2), agree (3), and strongly agree (4). Content validity was established through expert review by school of nursing faculty, a nurse research scientist, pastoral care, and physicians and nurses from the emergency department. Content validity was established through expert opinion from the school of nursing faculty, a

nurse research scientist, a pastoral care team member, emergency department physicians and nurses from various units within the hospital.

A total of 202 healthcare providers responded consisting of 98 nurses, 98 doctors and 2 respiratory therapists. Family members and patients were excluded from the study if they were less than 18 years of age. A total of 72 family members and 62 patients responded. Overall, healthcare providers had a positive attitude toward family presence. Duran et al. (2007) saw several themes emerge from the healthcare provider qualitative data. One was a major concern for the safety of patients and patients' families. There was also the concern about the emotional response the family members would have to witnessing resuscitation. Healthcare providers also expressed feelings of performance anxiety in front of patients' families. Responses from the family members revealed that they felt it was their right to be at the bedside during resuscitation and/or an invasive procedure. Among the 19 family members who had witnessed resuscitation and/or an invasive procedure, 95% answered that they would do the same in a similar situation and being with their loved one was helpful. The scores for patients did not have a significant difference between those who previously had family at the bedside during resuscitation.

Duran et al. (2007) concluded that family presence be studied in non-academia hospitals and that medical surgical units be included to allow for more generalizability of findings. The authors concluded that family presence is becoming a more acceptable practice and may benefit both patients and patients' families. The authors stated it would be beneficial if future research would focus on a shorter survey that includes scale items that potentially increase the response rate from healthcare providers. Family presence

can be effectively and safely implemented with a multidisciplinary approach and recognition of each care situation regardless of the size of the healthcare facility.

Parental Presence during Pediatric Resuscitation

FPDR continues to be a topic of controversy with the advantages and disadvantages identified; however, few studies have investigated the parents' experience. Furthermore, minimal research has been conducted in regard to parental presence during a successful pediatric resuscitation. Maxton (2008) conducted a qualitative design study to obtain a deeper understanding of the meaning for parents to be present or absent during their child's resuscitation in a Pediatric Intensive Care Unit (PICU).

The setting was a 20-bed PICU located in a tertiary pediatric hospital located in Australia. The unit admitted children ranging in age from newborn to 16 years. The largest number of admissions was for patients requiring correction of congenital cardiac abnormalities. Purposive sampling was used to enroll participants whose child had been admitted and subsequently required CPR. This technique allowed recruitment of those best informed about the experience. Eight parent couples were recruited and an additional two parent couples declined. As a variety of experiences were sought, Maxton (2008) included parents whose children either survived or had died and parents who had either been at the bedside or absent during CPR. Four children did not survive and at least one parent of these children had been present during CPR. Parents who had been absent had either been prevented by staff from remaining bedside or were absent during CPR. All these children survived. All the children were aged between six months and five years.

Data were collected using in-depth, unstructured interviews conducted with either one (n=2) or both parents (n=6) yielding a total of eight separate interviews. Maxton (2008) concluded all interviews with “Tell me what it was like to be there when your child needed to be resuscitated?” The interviewer then probed deeper into areas raised by participants. All interviews were audio-taped and transcribed verbatim. Texts were entered into a qualitative data program for management. Interviews lasted approximately 90 minutes and were usually conducted in parents’ home or quiet room near the hospital unit.

Data were analyzed utilizing van Manen’s (1990) framework and employed a two layer approach. Listening to the tapes, reading and re-reading transcripts and studying field and reflective notes was followed by line by line thematic analysis. This led Maxton (2008) to the construction of thematic statements and subsequently four themes. Additional hermeneutic phenomenological interpretation provided the second layer of meaning by providing understanding of what it is to “be” a parent in this sensitive situation.

Findings from Maxton (2008) revealed four major themes that captured the parents’ experiences: (1) Being only a child; (2) Making sense of a living nightmare; (3) Maintaining hope in the face of reality; (4) Living in a relationship with staff. These overlapping themes are intrinsically connected, contributing to the shared interpretation of the phenomenon of “sharing and surviving the resuscitation”. The author also concluded that nurses need to be educated on providing appropriate support to parents

with their decision to be, or not to be, present during resuscitation efforts of their children.

Family Experiences at a Children's Hospital Emergency Department

FPDR continues to be viewed as a relevant yet controversial subject. Additional information is needed in regard to the family members' perception of experiences during resuscitation at a children's hospital emergency department. McGahey-Oakland, Lieder, Young & Jefferson (2007) conducted a study that would facilitate development and implementation of policies surrounding FPDR during pediatric resuscitation. There were three objectives for the study:

1. Describe experiences of family members that went through resuscitative efforts in an emergency department of a children's hospital.
2. To acknowledge that family members should be viewed as experts to identify crucial information that will serve beneficial in assisting future families through the process.
3. Assess the mental and health functioning of the family members that have experienced FPDR in a children's hospital.

The study sample consisted of family members of patients that were identified through a hospital quality improvement project at Texas Children's Hospital. The hospital's institutional review board approved the study and, due to the sensitivity of the subject, the institution required very strict inclusion criteria. McGahey-Oakland, et al. (2007) included participants that were English and/or Spanish speaking adult family members of children undergoing CPR prior to their arrival at the hospital emergency department between March 2002 and April 2003. The patient's chart had to include a

CPR flow sheet that was submitted to the CPR committee for review. There were 25 charts that met the inclusion criteria. Of those 25 patients, 10 patients had family members interviewed; families of 9 patients declined to participate and 6 patient families were lost in the interview and follow-up process. The interview breakdown consisted of: 7 mothers, 2 fathers, and 1 Great-Grandmother 1. Three of the children had a chronic illness and 7 had acute life threatening events. All 10 children expired after resuscitation efforts.

To gather quantitative and qualitative data a previously validated and reliable tool, Parkland Family Presence during Resuscitation/ Invasive Procedures Unabridged Family Survey (FS) was utilized by the authors. The FS and five investigator-developed procedural questions regarding FPDR were used for obtaining information about family member experiences with resuscitation. The FS is a 32 item family survey with 10 demographic items and 22 open ended questions. McGahey et al. (2007) obtained permission from the participants.

Whether present or not, all family members expressed positive significance of having the option to be present during the resuscitative efforts. Quantitative results displayed that family members had a mean FPAS-FM score of 24.1 (SD = 4.9, Mdn = 24), with a possible score range of 15 to 60. McGahey et al. (2007) identified five themes from the qualitative data collected:

1. "It's my right to be there." All 10 members answered this.
2. Connection and comfort make a difference. Caregiver connection to a child is unique.

3. Seeing is believing. Family members present felt everything was done to help their child.
4. Getting in. The family members physical location during resuscitation.
5. Information giving. Regardless of dealing with acute condition or chronic illness, none felt prepared to face the event of resuscitation.

McGahey et al. (2007) concluded that the results from the small sample provided insight into the family members' experiences; results cannot be generalized to all patient settings. The findings also revealed inconsistency in mechanisms for FPDR. The family members input dispelled proposed disadvantages with FPDR. Regarding the concern for disruption during CPR the families shared that it was important to them not to get in the way of the health care providers. Based on the results of the study, it was of opinion that the development and implementation of a formal policy on FPDR would assist RNs with consistency in managing family members at the bedside during resuscitation efforts.

Spirituality and Support for FPDR

FPDR and invasive procedures have been studied from various perspectives. One point of view that has not had a great amount of research is to look at FPDR from a spirituality standpoint. Baumhover and Hughes (2009) conducted a study to uncover the relationship between spirituality of health care professionals and their support for FPDR during invasive procedures or resuscitative efforts of adult loved ones.

Participants in the study were required to be licensed physicians, physician assistants or nurses that had worked in a critical care setting such as the emergency department or intensive care unit. Baumhover and Hughes (2009) used a convenience

sample, self-sampling method utilizing flyers that were placed in visible areas, a letter sent by the researcher and word of mouth encouragement from a nursing leader. The institutional review board granted permission to conduct the study and participants signed an informed consent to participate.

The authors found several tools that measured spirituality; however, the limitations of most of these tools either limit their focus on religious belief and experiences or the measurement of a patient's actual spirituality. After obtaining permission, Baumhover and Hughes (2009) used a spiritual and support (SAS) tool developed and devised by Howden. This tool is a holistic assessment instrument with comprehensive meaning and consists of 28 items that are rated on a 6-point Likert scale. Content of the scale was validated by 6 experts in the field of spirituality and spiritual health and also subjected to a pilot test to assess readability, reliability, and validity.

Out of the 115 eligible participants, a total of 108 participated with the following breakdown: 73 nurses, 31 physicians, and 4 physician assistants (PAs). The nurses' results were put in one group. Due to the low number of PAs, PA data were collapsed into the group with the physician data to form a total of two separate groups (nurses and physicians/PAs). Data analysis revealed that 58% of the nurse group, compared to 34% of the physician group, strongly agreed that family presence is a patient's right. Baumhover and Hughes (2009) found no difference in the interconnectedness attribute associated with spirituality between the 2 groups. The study suggested a relationship between holistic perspective and support for family presence. The higher the scores of

spirituality for the health care professionals, the more likely they were to support the FPDR practice and view it as a right of the patient.

Baumhover and Hughes (2009) concluded that further research is needed to focus on FP during invasive procedures including the different levels of invasiveness.

Timeliness of a patient's impending immanent death with family present also needs additional exploration. For example, impending immanent death during an unexpected acute trauma situation versus an expected probable deterioration in a patient's status.

Other areas of further interest might include physicians' preferences, performance anxiety and level of receptiveness between health care providers about FPDR.

Baumhover and Hughes (2009) study does begin to fill some gaps in existing literature; this was the first study to yield results indicating that the spirituality of the health care professional has a relationship to the support for family presence.

Impact of multifaceted intervention on nurses' and physicians' attitudes and behaviors

The studies conducted relatively recently, 2007 and 2009 on the attitudes of nurses and physicians toward family presence during resuscitation (FPDR) have focused on retrospective or cross-sectional data from staff surveys. Such research has revealed that healthcare providers continue to have mixed opinions concerning the value of FPDR. Even though recent studies support the implementation of FPDR, few reports have been published that detail actual programs or strategies for instituting this practice. In a recent study of emergency and critical care nurses, researchers found that only 5% of hospitals

had a policy on family presence and only 27% of the nurses were aware of the guidelines issued by the Emergency Nurses Association in 1995 (Mian et al., 2007).

The purpose of a study conducted by Mian, et al. (2007) was 2-fold: to design and implement a family presence program in the emergency department and to evaluate the attitudes and behaviors of nurses and physicians toward family presence before and after implementation of the program. Their study took place in a Magnet facility with 898 beds in an urban academic medical center located in the northeast. The sample included all nurses and physicians working in the emergency department who agreed to complete the surveys at two points, at the start of initiating a family presence program and 1 year after implementation of the program. The initial survey was completed by 86 nurses and 35 physicians and the follow up survey was completed by 89 nurses and 14 physicians. Demographic data included age, sex, educational level and experience in the emergency department.

The survey was anonymous and consisted of 3 parts designed to measure the major factors believed to influence the staffs' willingness to adopt a family presence program. A 30 item Likert scale was used to measure attitudes, values and behaviors. Each question had 5 potential responses, with 1 being "strongly agree" and 5 being "strongly disagree." Twelve questions addressed the personal and professional experience with family presence. Mian et al. (2007) relied on twelve former emergency department nurses to pretest the initial survey and after minor revisions; internal reliability was acceptable for all items and subscales.

Findings from Mian et al. (2007) revealed consistency with findings from previous studies on the attitudes of nurses and physicians regarding family presence. Both surveys displayed nurses having stronger support for the rights of patients to have their families present than physicians. Additional findings revealed physicians support family presence in some circumstances but continue to feel ambivalent about family members observing how they manage patients. Findings in this study also showed participants believe family presence is a nurse-driven practice.

Canadian Nurses' Perspectives on FPDR

International research on FPDR has been conducted in many countries including but not limited to, the United States, Turkey, Ireland, Australia, and several European sites. However, minimal work has been published from a Canadian perspective. To address this gap in research, McClement, Fallis and Pereira (2009) conducted an on-line survey with Canadian critical care nurses as part of a larger program examining FPDR.

The 18 item survey collected demographic data and asked questions about nurses' preferences, practices and hospital/professional organizations position on FPDR. The authors also included an open ended question on the survey inviting the respondents to elaborate on FPDR on their unit or on a professional or personal level. 252 of the nurses taking the survey responded to the qualitative question with answers ranging from 1 line of text up to 20 lines of text with 4 being the average length of response. For this research article, McClement et al. (2009) presented the findings from the qualitative data.

Following appropriate approval, the survey was sent to a convenience sample of 944 nurses that were members of Canadian Association Critical Care Nurses (CACCN)

who had previously provided an email to the CACCN to facilitate membership communication. With permission, McClement et al. (2009) modified the survey patterned after MacLean and colleagues to take on a Canadian context regarding the CACCN position statement about FPDR.

Findings from McClement et al. (2009) revealed an overriding theme that captured the way nurses discussed their perceptions of and experiences with FPDR was that of risk-benefit calculation. From the nurses comments it was evident that they reflected thoughtfully and carefully about the advantages and disadvantages of FPDR and their decision was based on a variety of factors that carried both benefits and risks for the patient, family and health care provider.

The authors concluded that bringing a family member to the bedside during resuscitation of a loved one is not easy, it is a complex situation. Contributing to the complexity are the risks and benefits to the patient and family members that must be considered as well as the cultural environment. McClement et al. (2009) also conclude that research is needed that gives a voice to those who have first hand experience of FPDR.

Australian Study on the Impact of FPDR

A common practice in emergency departments in Australia has been to exclude family members from the patient room during resuscitation. However, several researchers believed that families and patients were better served when they weren't left out but there was lack of evidence to support that practice. Holzhauser, Finucane and DeVries (2006) conducted a randomized controlled trial in an attempt to reveal the

impact on family members who were allowed to be present during resuscitation. The authors' collective opinion was that additional information was needed as they could not find Australian studies on the subject and most of the literature overseas was anecdotal with minimal structured research having been conducted. A three year research project was conducted that focused on three main areas:

1. Is there a difference in staff attitude to relatives' presence in resuscitation after the implementation of the project?
2. What were staff attitudes to relatives' presence in resuscitation immediately post resuscitation?
3. What are relatives' attitudes to being present during resuscitation?

Family members whose relative was resuscitated were randomized upon arrival to the emergency department and surveyed one month later. This research served as a baseline for Holzhauser et al. (2006) to utilize as a starting point of scientific based evidence. The authors conducted an extensive literature review where they found only seven research-based articles based on the experiences of the relatives. There was one Australian publication that loosely focused on the subject, but again it was not research based.

Based on the dominance of opinion-based publications, Holzhauser, et al. (2006) conducted a randomized controlled trial method in an effort to provide structure on the topic area. The inclusion criteria for patients to meet for resuscitation were: a triage rating of 1 or 2, with or without an altered level of consciousness or a Glasgow Coma Scale (GSC) reading of 13 or less; hypotensive; respiratory distress or the need for

cardiopulmonary resuscitation (CPR). Trauma cases were excluded to maintain consistency between the control and experimental groups. Relatives of the selected patients, presenting to a Queensland (Australia) emergency department, were randomized to either the control group or the experimental group based on the following inclusion criteria: over 18 years of age, immediate family member or significant other present, informed written consent, presence of a trained healthcare provider for support and the relative could not behave in a disruptive manner during treatment. Due to the limited number of studies available, the research team determined a sample size goal of 40 for the control group and 60 for the experimental group.

A survey tool of 10 open-ended questions was used. The questions maintained continuity between the two groups, however, Holzhauser et al. (2006) did include questions that were worded to suit the individual being interviewed based on the outcome of the patient. The questions were based upon experiences of clinical staff and the review of the literature. For content validity, the survey was analyzed by the research team after piloting the tool on the first 10 family members participating in the study. Demographic data were also collected to determine age and relationship to patient. During the development of the tool, the team felt the answers to the questions may be influenced if the individual worked in a healthcare field; so, an additional question identifying their occupation was added. There were many ethical issues to consider with this study and it was approved by the hospital's Human Research Ethics Committee.

Holzhauser et al. (2006) divided the results into three areas of questions for reporting. The questions were related to: demographics, relatives' experiences and

support from staff while in the emergency department. Demographics displayed the majority of family members were spouse/partners with 55.2%, for the experimental group and 51.7% for the control group. Experiences showed a total of 58 families from the experimental group that were present during CPR, with the most common response being, “I preferred to be present”. Results for support during CPR displayed 67% responding “yes” to want to be at the bedside. Every family were glad they were there and both groups reported good communication with staff.

The authors concluded that many family members are grateful to be present during CPR. There was a positive association between families being present and the patient benefitting from their presence. These findings provide a preliminary analysis of the issue surrounding the presence of relatives during resuscitation. Holzhauser et al. (2006) recommends an open communication policy to all staff that allows for clarification of the project and to provide the opportunity to discuss concerns. Findings of the study also highlight the importance of the support staff in the overall care of the patient and their relatives.

Summary

Literature review regarding FPDR reveals mixed feelings and perceptions among healthcare providers and a trend toward families desiring to be present during resuscitation. There exists a deficit in FPDR research among nurses outside of the emergency departments. Given that fact, additional research regarding nursing staff attitudes from various care settings is warranted. The findings from such studies would add to the research body and allow for further education and exploration on the topic of

FPDR. Nursing standards and guidelines can be developed based on the evidence to support the practice or not support the practice of FPDR.

Chapter III

Methods and Procedures

Introduction

Nurses' actions and attitudes have a significant impact on the patient and families they care for. Allowing family members to be at the bedside of a loved one during cardiopulmonary resuscitation or an invasive procedure is an important decision with potential for long-term consequences. Published data to date have focused on acute care settings. Nurses in any given patient care area of an organization must be knowledgeable and feel supported to make such decisions. This study is a partial replication and expansion of Knott and Kee's (2005) study. The purpose of this study is to explore current (2010-2011) family presence during resuscitation (FPDR) beliefs and attitudes of registered nurses who provide care to all ages of patients in a variety of hospital care settings.

Design

The study is at a basic level of qualitative descriptive methodological design using maximum variation sampling procedures with a restricted sample size. The purpose of descriptive research is to describe concepts and identify relationships among variables (Burns & Groves, 2009). A semi structured open-ended interview schedule/questionnaire will be used, allowing respondents to voice their beliefs, feelings and experiences.

Setting, Population and Sample

After approval from the Ball State University and hospital's Institutional Review Boards (IRB), the study will be performed at a 160 bed county owned hospital located in the Midwest. The target population will consist of a minimum of 10 nurses and a maximum of 30 nurses from various Hospital practice settings, each with at least 4 years of experience. The nurses must have witnessed or participated in cardiac resuscitative efforts where families were available on site.

Protection of Human Subjects

This study will be submitted to and approved by the hospital's IRB. Patient identity will be protected and identifiers limited to age, sex and first letter of patient's last name. Respondent's identity will be known only to the nurse researcher. Each respondent will be given an identity code number. The primary investigator is an acquaintance of all potential participating nurses and will inform each of them of the opportunity to be a study participant. Each participant will be asked to sign a written consent including permission to have the interviews tape recorded.

Procedures

All interviews will be tape recorded and transcribed verbatim by the nurse researcher to ensure accuracy and to allow for additional data analyses. The interviews will last approximately 45 minutes and take place in a mutually agreed upon private area. Each respondent will only be interviewed once. Nurses will be asked to provide the following demographic information: age, gender, highest nursing degree or diploma,

certifications held, religious affiliation, type(s) and length of clinical experiences, and whether parent(s) sibling(s), or spouse are a nurse or physician.

The interview questions were adapted and expanded from the Parkland Health and Hospital System (1997), survey and focus on the nurses' experiences and beliefs surrounding FPDR. This questionnaire will be utilized as it is brief, contains open-ended questions, focuses on the targeted concept and is designed for hospital staff. The interview process will begin with confirming the nurses' involvement with CPR and move to their beliefs surrounding FP. The nurse researcher will ask questions in a non-biased tone and her facial expression will remain neutral throughout the interview. At the end of each interview, all nurses will be asked if they would like to offer any additional thoughts regarding the subject of FP.

Research Questionnaire

The interview questions for this study were identical to those from the Knott and Kee (2004) study.

Interview questions.

- Have you been involved in cardiopulmonary resuscitation? Approximately how many?
- Tell me your beliefs regarding FPDR?
- If you were ill or injured, would you desire your family to be present during your resuscitation?
- If your family member were ill or injured, would you like to be present for his/her resuscitation?

- Have you been present for a loved one's resuscitation?
- On what should the option of adult family presence depend?
- Have you participated in a resuscitation during which family members were present?
- If not, why? If so, please tell me about the experience.
- Were you comfortable or uncomfortable with FP?
- What were your greatest concerns regarding the family's presence?
- Was the experience what you expected?
- What was the family's behavior? Did you consider the family's behavior appropriate?
- Generally speaking, was the experience positive or negative either for you, the family or the patient?
- Has your attitude toward FPRD changed as hospitals gone from open wards to quad rooms to semi-private rooms to current private patient rooms? If so, please describe.
- Have you experienced a change in patient or family expectations regarding FPDR since you started your nursing career? If so, please describe changes observed.

Data Analysis

Demographic and background data on age, nursing education, and years of clinical experience will be grouped into categories then summarized. The responses to the interview questions will be analyzed using a constant comparative mode of data

analysis. The constant comparative method entails comparing variables in one interview with those in another interview. This process is repeated until the content of each interview is compared with content in all other interviews and major themes identified. Dependability and credibility will be validated by having two study participants read the condensed results for accuracy and then determine if these findings reflect what was true for them.

Summary

This chapter described the methods and procedures to be utilized for this study that will be at a basic level of descriptive qualitative research. The specific elements examined will be the nurses' current beliefs and attitudes about family presence during cardiopulmonary resuscitation from a variety of care settings. Data will be collected through semi-structured interviews using open-ended questions. This study, a partial replication and expansion of a previous study conducted by Knott and Kee (2005), will attempt to validate findings from previous North America and International studies, contribute to the body of knowledge regarding nurses' beliefs about adult family presence during resuscitation and serve as a basis for establishing a Hospital family presence during resuscitation program relevant for today's Midwest society.

By nature, nurses persevere with the patient at the center of care. As the FPDR debate continues to march to the forefront, nurses will strive for what is best for each individual patient and family. This may, or may not, include having family present at the bedside during the highly stressful life event called resuscitation.

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